

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION****PART I: GENERAL INFORMATION**

Requestor's Name and Address:  EL PASO SPECIALTY HOSPITAL 1755 CURIE SUITE A EL PASO TEXAS 79902	MFDR Tracking #: M4-04-0875-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Box #:  TEXAS MUTUAL INSURANCE CO. Rep Box # 54	Employer Name:
	Insurance Carrier #:

**PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION**

Requestor's Position Summary: "It is our understanding that benefits were significantly reduced due to your determination that the billed charges are more than the usual and customary rate for certain procedures or items." "We do not believe the reduction is justified. As you are likely aware, such provider reimbursement rates are typically adjusted based on the usual and customary treatment charges for that specialty and the geographical region where the treatment was provided. Further, many state and federal disclosure laws require insurers and administrators to advise beneficiaries and providers as to how the reimbursement rate is determined. However, the payment rendered does not appear to be comparable to rates charged for this service locally and no information has been given to support your position that the denial is correct."

## Principal Documentation:

1. DWC 60 Package
2. Total Amount Sought - \$1725.63
3. Hospital Bill
4. EOBs
5. Medical Records

**PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION**

Respondent's Position Summary: "It is this carrier's position that a) the disputed date of service is out of jurisdiction, b) the requester failed to produce any evidence that its billing for the disputed procedures is fair and reasonable; c) this carrier's [sic] payment is consistent with fair and reasonable criteria established in Section 413.011(b) of the Texas Labor Code; d) Medicare fair and reasonable reimbursement for similar or same facility services is below this carrier's, and e), the Commission has concluded that charges cannot be validated as true indicators of the facility costs." "Consequently, it is this carrier's position that no further reimbursement is due the requester."

## Principal Documentation:

1. DWC 60 Package

**PART IV: SUMMARY OF FINDINGS**

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
3/10/2003	M, T2, JX, YO	Outpatient Surgery	\$1725.63	\$0.00
<b>Total /Due:</b>				\$0.00

## PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
  - M-No MAR.
  - T2-Reduction was made on outpatient bill.
  - JX-Fair and reasonable reimbursement for the entire bill is made on the 'O/R service' line item.
  - YO-Reimbursement was reduced or denied after reconsideration of treatment/service billed.
2. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Division rule at 28 TAC §133.307(e)(2)(A), effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires that the request shall include "a copy of all medical bill(s) as originally submitted to the carrier for reconsideration in accordance with §133.304." This request for medical fee dispute resolution was received by the Division on September 18, 2003. Review of the documentation submitted by the requestor finds that the requestor has not submitted a copy of the original bill. Therefore, the requestor has failed to complete the required sections of the request in the form, format, and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(e)(2)(A).
5. Division rule at 28 TAC §133.307(g)(3)(C), effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires the requestor to send additional documentation relevant to the fee dispute including "a statement of the disputed issue(s) that shall include: (i) a description of the healthcare for which payment is in dispute, (ii) the requestor's reasoning for why the disputed fees should be paid or refunded, (iii) how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues, and (iv) how the submitted documentation supports the requestor position for each disputed fee issue. Review of the submitted documentation finds that the requestor did not discuss or explain how the Texas Labor Code and Division rules impact the disputed fee issues, or how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(C).
6. Division Rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §133.1 of this title (relating to Definitions) and §134.1 of this title (relating to Use of the Fee Guidelines)". The requestor's position statement asserts that "We do not believe the reduction is justified. As you are likely aware, such provider reimbursement rates are typically adjusted based on the usual and customary treatment charges for that specialty and the geographical region where the treatment was provided." Review of the submitted documentation finds that the requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated. The requestor does not further discuss or explain how the amount in dispute was calculated or arrived at. The requestor does not explain how it determined that payment of the amount in dispute would result in a fair and reasonable reimbursement for the disputed services. The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the statutory requirements and Division rules. Nor did the requestor submit evidence, such as nationally recognized published studies, Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments, to support the requested reimbursement amount. Review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that the payment amount sought is a fair and reasonable rate of reimbursement. The request for additional reimbursement is not supported. Additional reimbursement cannot be recommended.
7. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute

was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(e)(2)(A), §133.307(g)(3)(C) and §133.307(g)(3)(D). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

#### **PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311  
28 Texas Administrative Code §133.307, §134.1, §133.304, §133.1  
Texas Government Code, Chapter 2001, Subchapter G

#### **PART VII: DIVISION DECISION**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

#### **DECISION:**

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

2/12/2010

\_\_\_\_\_  
Date

#### **PART VIII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**